When the superintendent answers, you speak to him as follows: 'Dear Mr. Superintendent, here I have a very fine barometer. If you will tell me the height of this building, I will give you this damn barometer.'"

I think an essential lesson lies somewhere between this story and the issues I raised with you this morning. For the most part, I have tried to set the stage for the sessions to follow and for the deliberations necessary in the months ahead as you work toward the development of a certification program. Wherever possible, I have dealt in generalities. The list of specifics, however, is lengthy, complex, almost unending, yet not overwhelming. It includes such things as:

- Developing a sense of perspective, where you really want to go
- Identifying an appropriate program accreditation agency
- Putting together the concepts of a licensing examination
- Developing an RFP for test service agencies...and so on.

As you undertake these tasks, you are going to need to talk, confer, maybe even argue with those of us who have already "been there." After all, there is nothing to be gained in spending time and money "rediscovering the wheel." Unfortunately, there are many self-proclaimed experts in this area, but a smaller number of us that have spent most of our professional lives "with the troops" and who have been a part of the exciting changes now taking place in credentialing. For example, we have seen and participated in the development of the National Commission for Health Certifying Agencies, an organization that I believe will ultimately prove to be a key to the future success of the voluntary credentialing programs in the health area and one that has education of leaders of health occupations as a major goal.

Those of us who believe in credentialing and who are dedicated to the betterment of the system are always available to you as the need arises, but like Calandra's student, you must be the masters of your own

critical thinking. During these next few days and in the months that follow, I can only encourage you to take heed of what you have heard; consider the critical points; try to put the pieces together that are meaningful to you, in whatever fashion you decide is most suitable for your organization; and do so in a common-sense manner. Feel free to ask questions, talk to us as you need to, then collectively and through the governance of your association, make your own choices, hopefully in such a manner that rapid changes can be accomplished to meet changing demands as they may occur in your own situation. We are here to help, to advise, but your role is to make the decisions.

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Perspectives on Role Delineation

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The purpose of this presentation is to address some of the significant features of the development of the initial role delineation document and ongoing activities of the Role Delineation Project. As can be seen from the other presentations made at this conference, the Project shares a broad historical base in professional preparation that covers many decades. In turn, the Project's activities are pointed toward developing a consistent and broadly based system for assuring that health educators are in a position to contribute to furthering the maintenance and improvement of the health of the public for the immediate and long-term future. Credentialing systems present difficult challenges to the profession; yet they can enhance the delivery of better health education services to the publics we serve.

For more than two years, the role of practicing health educators working in community, medical care, school and other settings has come under intense scrutiny. Through the Role Delineation Project, consistent with past efforts, the current investigation is pointed toward systematic strengthening and improvement of the preparation and practice of health education specialists. Yet the Role Delineation Project, in its organization and processes, is different from these past attempts.

For example, support for the current effort is significantly different from that for past studies. In this case, the Division of Associated Health Professionals, part of the Health Resource Administration's Bureau of Health Professionals, DHHS, has contracted with the National Center for Health Education to conduct the study. The Center, a nonprofit educational corporation that evolved from one of the principal recommendations of President Nixon's Committee on Health Education, functions independently of the professional associations to which

health educators belong. The Division of Associated Health Professions' contract activities in role delineation studies are a derivative of Congressional legislation that seeks to assure the public a basic level of quality for services rendered by allied health professionals. As a consequence, a number of health professionals, in various stages of professional development, have undertaken role delineation studies. As part of the contract requirements, it is incumbent upon the contractor and those directly involved in the Project to include all facets of professional practice as part of role delineation activities. Continuation of Federal support for each phase of the Project is contingent upon successful completion of each contract, acceptance of each contract's outcomes by the profession as represented on the Project's Advisory Committee, and ongoing availability of Federal funding.

The Project's Advisory Committee is made up of representatives of eight national health education organizations plus representatives of consumer and employer interests, and of health education in medical care settings. The National Task Force members, who initiated the Role Delineation Project, serve on the Advisory Committee in their roles as representatives of the professional associations. Thus there is a broad scope of representation of various interests involved in the preparation and practice of health educators.

Another novel aspect of the Role Delineation Project is its concentration upon the role of the entry-level practitioner. As part of the Congressional mandate that resulted in role delineation studies, the focus is upon basic levels of quality for services rendered by health professionals. Other professions have established a wide range of methods to ascertain basic or entry level. Among the various criteria are most often one or more of the following: educational attainment, a period of supervised field experience following graduation, and examinations administered to certify or license individual practitioners on a voluntary or mandatory basis.

Identifying the point of entry into the profession has proven to be among the more troublesome areas for other professions in different ways. For example, the American Physical Therapy Association has called for elevating entry level into physical therapy to the Master's degree level by 1990. This has implications not only for current practitioners, but for student/consumers, educational institutions, employers, third-party payers, and public policy makers. Ultimately, the public will bear the brunt of such professional decisions. For health educators, care must be given to establishing one or more entry levels for the profession. The intitial definition of entry level at the baccalaureate level must be carefully examined against the field of practice.

The focus on entry-level, or basic level, preparation leaves open a great many unanswered questions. If we can delineate the role(s) of entry-level health educators, what is the role of an advanced-level health educator? What do employers expect of entry-level practitioners? Will one role for an entry-level practitioner be sufficient to include all of the practice settings in which health educators are found? Is there only one level of entry into the profession? Are we talking about entry as a professional health educator, or are we talking about entry into specific settings? Answers to these questions may be found in surveying the field of practice, a survey which the National Center for Health Education will conduct as a companion to our current role delineation activities.

Another facet of the entry-level question revolves around the necessity for supervision. Those participating in the initial phase of the Project observed that while entry-level health educators should be supervised, such is often not the case. Undoubtedly, this situation contributes to an erosion of professional identity early in the career of any health educator. Reinforcement through peers or colleagues is often inadequate or absent. Coupled with an acknowledged deficiency in the field of a network of continuing education programs, this weakens an already ill-defined professional identity for health educators. Even experienced and capable health educators are often repeatedly asked to

justify or define health education for their employing organizations. How often must the field and the profession be defined and redefined? Admittedly, we are in a rapidly evolving field that is gathering itself together, both as a profession and in skills offered.

In addition to the funding and organizational support, focus on entry level, and supervision of health educators, the basis for the development of the initial role differs widely from past efforts. A cursory review of the preparation statements developed by the various associations reveals that they were developed in a manner that suited the purposes of each organization. That is, school health education statements on preparation reflected the interests of school health educators, and, in a similar fashion, public or community health education statements were prepared to meet the needs of the sponsoring organizations. With all of the organizations represented on the Project's Advisory Committee and the Federal Government providing fiscal sponsorship, it became impossible for the initial role specification to be couched in a way that reflected a dominance by any one association.

Early in the initial phase, one of the first decisions was to attempt to describe a common entry-level role for all health education practitioners. The decision was based upon a careful analysis of the proceedings of the Bethesda Conference (1) that preceded the Project. As part of the proceedings, the participants envisioned circles of functions that overlapped among school, community, and medical care settings. In the center of the three overlapping circles was a shaded area that reflected functions shared by health educators in all three work settings. The Project's Working Committee hypothesized that the shaded area of common functions was much larger than that depicted.

Among the difficult tasks in developing a common, or generic, role was the selection of terminology that would be commonly accepted and understood by health educators in all settings. No such terminology existed in the profession. This had the hazard of potentially rendering

the initial role specification meaningless to the constituency for whom it was intended. In spite of the obstacles presented, the initial role specification contains language that was mutally acceptable to those involved in the Project from various preparation, practice, and professional association backgrounds. This was accomplished by using consensus as the principal decision-making process.

As a consequence, production of the initial role specification required six meetings of the Project's Working Committee in less than a year's time. Much of the time spent in meetings was devoted to testing proposed role content not only for its relevance to practice but also for acceptability of the terms selected. The result was determined to be representative of the field of practice.

In addition to the proceedings of the Bethesda Conference, staff and the Working Committee based the initial role specification upon a wide variety of available resources. First, staff solicited and collected job descriptions from health educators wherever they could be found. Over six hundred were accumulated. Of those, more than three hundred were analyzed and compared to the drafts of the role specification in order to insure comprehensiveness. Thus the perspective of employers was included in the initial role specification.

Second, professional preparation guidelines from the various professional associations were collected and scrutinized. This assisted in selection of both content and language. Also, the literature of health education regarding preparation and practice found in journal articles, conference reports, and special publications was used. Thus the perspective of the profession was included in development of the initial role specification.

Third, many descriptions of professional preparation were gathered or made available during the course of the initial phase of the Project. These materials were useful in determining the "fit" of the role specification with the wide variety of professional preparation curricula.

Bear in mind that there have been more than 270 college and university programs of professional preparation identified across the country. As has already been noted, without a common focus for preparation, the curricula vary widely. Thus the perspective of the professional preparation programs was included as an additional factor in the course of developing the initial role specification.

Tying these perspectives together was the Role Delineation Working Committee, reflecting a diversity in preparation, professional experience, and professional affiliation. In their deliberations, both at meetings and in between, the committee members sorted through the accumulated materials, made comparisons, and evaluated the relevance of the collected data to the task at hand. Distilling the collected data through the various perspectives of the committee members resulted in the development of the initial role specification.

One other, and significant, deviation of this effort from past efforts in health education is the basis upon which the content is developed. While the content comes from the profession of health education, the format for the role specification is based upon the current concepts of criterion-referenced testing. As the other speakers will attest, a credentialing system for health education, or for any other profession for that matter, must be based upon the skills and knowledge that are indicative of successful, or at least acceptable, performance on the job. This is a significant departure from traditional credentialing practices. In the past, credentialing systems have relied heavily upon the standards of each profession in question.

Because of renewed interest in accountability of the professions and other social institutions, an examination of the association between professional standards espoused by professional associations and the need for protection of the public has evoked a strong suspicion that a significant gap exists between professional interests and the need for protection of the public against incompetence. Much of the focus of this concern is at the level of credentialing mechanisms, most notably

licensure among the States. While this appears to be separate from professional preparation concerns, experience and the literature point to the frequent association of educational attainment and licensure of individuals as a continuous process. For example, in medicine, graduation from an accredited school of medicine is a prerequisite for taking a licensing examination.

A remedy for the difference between public need and professional standards has been found in criterion-referenced testing. As first identified by Glaser in 1963, (2) criterion-referenced testing uses a standard of success based upon objective measures to gauge the capabilities of particular individuals. This is in contrast to traditional testing practices that attempt to determine an individual's status by some measure in relation to other individuals. Since 1963, numerous technologies have been introduced and refined to more fully develop and extend Glaser's original concept. These technologies are rapidly being implemented in the professions and business and industry as well as in education.

Popham, in his book, Criterion-Referenced Measurement, (3) depicts the basis for successful development of any criterion-referenced test as an explicit and complete description of behaviors that are essential to competent practice for any individual. It is essential, first, to identify the object that is to be tested. In this instance, it is the profession of health education. Competencies, in this usage, refers to behaviors that have been determined to be essential to acceptable performance of a service to society. Role delineation is the process used to determine essential competencies, which includes the identification of requisite skills and knowledge.

The Bureau of Health Professions has developed an outline of the credentialing program it sponsors. There are four phases of the process: Phase I--Role Delineation, Phase II--Resources Development, Phase III--Examination Development, Phase IV--Examination Administration.(4) For health education, we are currently involved in the first

phase. Initial role delineation has been completed, and role refinement and verification are currently under way. Once the role delineation phase is complete, the profession will be in a position to develop a mechanism to begin the process of developing a comprehensive credentialing system for health educators.

The first part of role delineation is intended to give a rough estimate of the field of practice for a particular profession. The sources cited above for the initial effort come from the available literature and expertise in the field.

The second part of role delineation comprises a major effort to refine the initial role delineation through tapping the experiences of practitioners in the field. For health education, this has meant using the initial role specification as a tool to interview practicing health educators so that revisions can be made to make delineation more parallel to practice. Subsequently, the revised delineation is being used to develop an instrument to be administered by the National Center for Health Education as part of a survey of practitioners. The data from practitioners will be used as the primary source for restructuring the role delineation to reflect the essential major and specific responsibilities of entry-level health educators. Included in the final product of the refinement and verification study are the skills and knowledge necessary for performing the role. Such skills and knowledge will be weighted according to their relative importance to practice in the various settings in which health educators work.

In addition to determining responsibilities and skills and knowledge, refinement and verification will identify one or more entry levels to the profession, ascertain the conditions of supervision under which health educators work, and determine the existence of a generic, or common, role for health educators at the entry level. The final product of refinement and verification will reflect the judgments of experts in the field, the literature of the profession, the perspective of employers expressed through job descriptions, interviews with practicing

health educators, a national survey, national workshops, round-table discussions, expressions from concerned individuals, and deliberations by two working committees and the Project's Advisory Committee.

The final product will be useful for carrying out subsequent role delineation processes in the other three phases. Yet the real decisions are left to the profession. Role delineation is designed to allow the health education profession to determine whether a credentialing system can be designed that is responsive to the needs of the public and useful to employers, public policy makers, and the profession. Once refinement and verification are completed, the development of educational resources and credentialing examinations will shift the burden of responsibility for developing implementation mechanisms from government-sponsored activities to the organization of the profession to meet the requirements of credentialing from pre-service education to continuing professional development.

Following refinement and verification, it is an essential first step in basic quality assurance to develop and disseminate curricular guides to help strengthen professional preparation as a forerunner of all other credentialing mechanisms. If, for example, the profession moves toward a certification program (generally, a voluntary effort using national standards in a qualifying examination), then it is essential that there be a core of health educators prepared who are eligible to demonstrate successfully their mastery of essential skills and knowledge. In addition, other devices, such as self-assessment documents and continuing education materials designed for practitioners currently working in the field, should be developed to strengthen practice and provide a basis for continuing professional development programs. This will assist those in the field to demonstrate successfully their proficiency in the skills and knowledge reflected in the certification examination. Also, to carry the example through, such self-assessment mechanisms and continuing competency materials would provide an opportunity to those who come into health education from alternative routes to develop their health education skills to a level

of proficiency consistent with the demands of basic quality as reflected in the certification examination.

As a final note, it should be recognized that role delineation provides the profession of health education with a process for the profession to determine its future. The process is a continuous one. The difficult first step is being completed. Improvements can be made during subsequent phases. New theory, discoveries from practice, research, demonstration, and the influence of the forces governing society can be systematically incorporated into the practice and preparation of health educators by retaining a process useful to professional growth.

As a result, consumers and employers will be in a better position to evaluate the services of health educators. Public policy makers will be in a position to knowingly allocate limited resources to the preparation and continuing professional development of health education personnel. Third-party payers will be able to establish meaningful standards for compensation for health education services, and the professional health educator will benefit from having marketable skills applicable to a wide variety of settings, with a career ladder and a sense of professional pride and responsibility.

The role of health educators is clear in Objectives for the Nation. But the time is short. In order to meet the challenge of effective and comprehensive health education in all aspects of society, the profession has little time for inaction. The objectives are meant to be attained by 1990. Through role delineation and the commitment of dedicated professionals, the challenge can be met.

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Implications of Credentialing's Importance for Community Health Educators

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Alfred North Whitehead has said that "[e]ducation is a setting in order of a ferment already stirring in the mind." Part of my task this morning is to assist in creating this ferment. Perhaps there is a need to stand back from the immediate problem of credentialing and to examine what is happening within the field of public health and within our own profession, and to make some judgments about how we should react to those situations. There is need to understand our relationships within health services and our relationship to the social, environmental, and health problems of the nation. Within this relationship of health education to the health problems of the nation, we should find the reasons for our concern with credentialing.

We should heed the advice of Gordon Allport, who warned of "the functional autonomy of motives." While we may all be deeply concerned with the need for credentialing, we must keep in mind that credentialing is an instrument. We need to be clear as to the purpose of the instrument, the usefulness of the instrument, and the acceptability of the instrument to the profession of the future.

It is a matter of some surprise to find that everyone is a health educator. Those holding M.S.W.s claim to be health educators; those with M.S.s, M.A.s, M.H.A.s, or M.P.H.s in planning--all claim to be health educators; almost without exception psychologists in public health claim to be health educators, whether their backgrounds be in clinical or social psychology; and there is even one woman of my acquaintance who majored in Classical Greek. I wonder, do we have a tiger by the tail?

As a national group of concerned academics charged with the responsibility of providing the competencies and skills that define the health education profession, we need to define our purpose or goal. This seems to be an essential first step in the process of defining roles. I would suggest three possible purposes for universities offering community health education programs.

Some may be concerned with the visibility of health education within the service structure of public health without particular concern for the methodology or professional role associated with such a service. A second possible definition of purpose might be the methodological area. Some may be concerned with providing the competencies and skills necessary to the efficient and effective health education of the public without particular concern for the professional identity of those who provide the education. A third definition of the purpose of an academic program in health education is the preparation of an exclusive group of people within the health sciences known as health educators. Presumably there is a body of knowledge and skills that define the profession. If we are to prepare, at the baccalaureate or Master's level, people called health educators, what are the essential competencies and skills without which a health educator is a charlatan and a quack? This is an essential question for the profession.

Our professional concern with entry-level preparation has coincided with a strong public demand for baccalaureate programs in health education. Universities have responded quickly to this demand, and my most recent information indicates at least two hundred university programs offering health education at the undergraduate level. There is no accurate figure for the number of people who are granted baccalaureate degrees in health education each year. My uninformed guess would be 2,000.

But there is no uniformity in this degree. Some degree of uniformity seems to be important if we are to consider certification or accreditation. Agreement on such uniformity will be difficult. Many

health education faculty have had no formal or informal exposure to the theory or practice of health education. Many come with biology, social science, or physical education backgrounds; and it seems difficult, if not impossible, to define a common body of knowledge within a university setting that may provide a professional base diverse from leadership within the university setting.

There is a further question of leadership within the programmatic area of community health education. For at least a decade there has been a large surplus of psychologists in the United States. This surplus will be accentuated in the coming decade. Furthermore, health manpower projections indicate a surplus of between 60,000 and 90,000 physicians by the year 1990. The impact of this surplus is already reflected in the number of physicians who are moving into the health education field. On the one hand, we have a large group of undergraduates with no uniform preparation, all claiming some skills and competencies in health education; and on the other hand, there is a large surplus of behavioral scientists and physicians interested in accepting leadership posts in health education. Many health education projects are directed by non-health educators and are staffed by people who wear the label of health education, but have few skills and little academic training in community health education. Is credentialing going to affect this situation?

The current emphasis on the entry-level health educator raises another question. What is the impact of our current concern and activity on the M.P.H. degree in health education? The SOPHE document on guidelines to the preparation and practice of health education provides our best current guide to standards. Any partial review of this document would suggest that the Master's degree is similar in almost every respect to the Bachelor's degree. This is confirmed in the role delineation document. There is no clear differentiation of skills; only a little more of the same. Particularly in the current era of economic stringency, perhaps we, as a profession, are contributing to the weakening of the professional category of the M.P.H. by our emphasis

on the wide range of skills and competencies delineated for the baccaleureate. Is this what we intend? While focusing on the standards for entry level, we must remain conscious of the total system and the impact of our efforts within that system.

Health educators have never been more fortunate in the resources available to them. The last decade has seen the establishment of two national offices, both of which have, in a short time and with comparatively slender resources, given fantastic support to the profession. We have a National Center for Health Education, highly active and privately funded. We have a large body of research, growing almost daily, that confirms the close association between the habits of people in their social and physical environments and the kinds of morbidity and mortality to which they are subject.

We have received in the last two years from the Surgeon General's office two volumes that support the whole concept of health education, and I speak here of two books, Healthy People and Promoting Health/ Preventing Disease. One calls for a second revolution in public health and provides feasible targets with particular emphasis on behaviorist aspects of health. Implicit in this publication is a challenge to health educators to provide leadership in this revolution toward new levels of health and a better quality of life. The second publication goes a long way toward laying out a health policy for the nation and emphasizes in this policy statement the concepts of health education and health promotion.

In the last year Larry Green and Helen Ross, with their co-authors, have provided us with two superb textbooks, thus offering the possibility of uniformity in teaching health education. The National Center for Health Services Research recently has issued RFPs on health promotion and disease prevention for the second time in less than six months. We have never had it so good.

Furthermore, and most important, the concept of health promotion has been separated from that of medical care by the Federal Government, and has thereby provided us with a firm professional platform. We have developed our guidelines, and the role delineation study is complete. These are big steps. But we are still a long way from professional monitoring.

In conclusion, I would like to bring up two further issues that have serious implications for community health education.

The first of these is constituency building. Ray Salman has told us to get out there and educate our public. While one or two of our members have outstanding records in building constituencies in the states, or at the national level, most of us have been content to be bureaucrats and to neglect or even avoid the task of constituency building. In our current cultural and political climate, we neglect constituency building at great risk. We must work to develop networks in our states and at the national level that provide visibility along with political and professional support. This seems essential to credentialing and to a professional identity.

My concluding point, one that supersedes all points I have tried to make, is the need for solidarity, to use a current term. Many professions in their adolescent stages go through fragmentation. This is but a reflection of diverse viewpoints and areas of specialization. In health education we are passing from adolescence to maturity. We now require specialization without fragmentation. We have at least six different organizations, each defending its own turf and claiming its own exclusiveness. Professionally this is suicidal. For too long the rift between school health educators and community health educators has been seen as a chasm, whereas in reality, it is little more than a ditch.

There is need for school health educators to extend their vision beyond the classroom to include the whole school system of teachers,

administrators, and parent groups. There is a concurrent need for the community health educator to recognize the strength of the school health educator and the powerful intervention modality that the school represents in our society. The situation does not call for a strengthening of coalitions but rather the abolition of petty fiefdoms and a consolidation of the profession into one professional organization. Specialization is essential and must take place, but must be built on a uniform body of knowledge, as in law or medicine.

In summary, can we define for ourselves a sense of our goals in professional preparation? Are we building on a philosophy of human relationships, or are we looking for a set of competencies? Are we working toward the strengthening of the "open society" concept of the independence and interdependence of people within their families and within their communities? Can we develop a consensus about the philosophy, competencies and skills that are the strength and distinguishing features of those who are proud to be called health educators?

Concerns About Credentialing Health Educators in Medical Care

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Certain characteristics of the medical care system profoundly affect criteria and prospects for credentialing health educators in this practice setting. To stimulate identification and discussion of the issues, this brief paper points out some salient features of medical care as it exists in the U.S. today and raises some related concerns for standards of professional preparation and practice.

1. The public, health care providers, and policy-makers are attributing increased importance to health education in medical care, but the reasons for this heightened interest differ. Consumers disenchanted with the existing system and newly conscious of their rights want straightforward information on their health status, their needs for medical care, the competencies of providers, and the risks and benefits of alternative courses of treatment. Providers are concerned about improving patient compliance with medical advice, as well as with conserving physician time. Institutions look to education as a new source of revenue in times of economic stringency, and also as a marketing device to assure high hospital bed occupancy rates. Legislators and insurance companies expect health education to help control health care costs. The anticipated outcomes of education in medical care therefore vary, and are not always compatible with goals of informed decision-making. Is credentialing to be concerned only with the effective performance of educational functions regardless of goals, or should the ends as well as the means of practice be considered? Whom shall education serve? What groups should it empower?

2. Medical care is organized to expedite the delivery of medical care, not education. Decision-making hierarchies, formal and informal lines of communication, leadership patterns, power relationships, work

priorities, buildings and architecture, and even the language of medical care are structured to facilitate the hands-on care of patients. The planning, organization, and delivery of effective educational programs therefore must take place in an environment laden with social and structural obstacles. Not the least of these is the problem of reaching agreement on the nature of educational content, for control of information is a major mechanism of social control in medical care institutions. To operate effectively in this milieu, the health educator must be able to assess the dynamics of complex and interacting systems, to gain acceptance and credibility in an alien culture, and to effect planned change, not only in individuals, but in organizations. Survival skills are prerequisite. While the generic role delineated for the health educator may be necessary, it is unlikely to be sufficient. What, then, is the appropriate preparation and entry level for health educators working in medical care?

3. Physicians, nurses, and other health professionals regard health education as their responsibility. Although this has been traditionally so, new emphasis on the importance of health education has led to new interest--and territoriality--on the part of various health professionals. Many physicians resist the provision of patient education by others on the grounds that only the doctor has full knowledge of the patient's case, that the doctor is held legally responsible for patient care, and that the involvement of others in education interferes with the doctor-patient relationship. Nurses, exerting their independence and expanding their own professional identity, claim that education is an integral part of quality nursing care. Dietitians, social workers, pharmacists, the clergy, and a host of other professionals similarly are specifying their particular educational roles and responsibilities in medical care, some with a good deal of sophistication. Related training programs and research projects, although variable in quality, not only visibly stake out turf but often contribute to strengthening educational practice. On what basis, then, can health educators claim that their skills and knowledge are unique? Rather than try to establish professional boundaries, shouldn't our stance foster interdisciplinary

collaboration and educational resource development? Isn't this politically the only viable alternative? And isn't such sharing the essence of education?

4. Massive social forces are converging to create enormous pressures for change in medical care. The decrease in infectious diseases and the increased prevalence of the chronic diseases, concomitant with changes in the age structure of the population, have altered needs and demands for medical care, as well as patterns of health care delivery. The technological explosion has expanded greatly the repertoire of medical interventions, leading to increased medical specialization, the mushrooming development of new health professionals, the uncontrolled growth of the health care industry, maldistribution of resources, and escalating health care costs. Business and industry, pressured by worker illness, rising insurance costs, and reduced profit margins, are organizing their own health programs and renegotiating relationships with medical care institutions. At the same time, the women's movement and increased consumer attention to equal access, quality care, and informed consent have thrust decisions about medical care into the political arena, as well as the legal/judicial system. Society's efforts to cope with these problems have resulted in a labyrinth of regulations, new forms of health care organization, and new financing mechanisms. None of these "solutions" has yet achieved notable success, but all have contributed to the intensity and turmoil of change.

Hospitals and other medical care facilities therefore are caught in an enormous economic and political struggle involving many sectors of society. The stakes are high and vested interests are strong. One result of particular relevance to the development and implementation of standards for health education specialists has been the declaration of a moratorium on the licensing of nontraditional health workers. Is credentialing of health educators in medical care feasible in this maelstrom of events? How can meaningful standards of professional practice be set when there is so much instability in the system? Will medical care institutions tolerate only the performance of those educational functions that preserve the status quo? And is "playing it safe" to protect

the availability of jobs in medical care more important to health educators than the challenge of applying education to help resolve fundamental difficulties in the relationship between people and their health care institutions?

The complexity and magnitude of these issues indicate that achieving quality health education practice in medical care settings is a formidable task. Standards unquestionably are needed when the well-being of patients--and sometimes even their lives--depend on educational effectiveness. Also necessitating the development of meaningful guides to professional practice are expectations held by various powerful segments of our society about the contributions health education can make toward alleviating major medical care problems and the desire of health education specialists to perform constructively in this important arena of change.

While the need for standards therefore is not disputed, questions arise about how standards best can be set. The delineation of a generic health education role accompanied by related curriculum development and credentialing efforts represents one approach. Nevertheless, before investing substantial professional resources in this endeavor, potential payoffs must be carefully weighed against those likely to be attained through alternative uses of limited time and energy.

In our considered view, professional standards must be derived from a thorough analysis of the educational needs of particular population groups combined with an assessment of the opportunities, constraints, and resources that shape health education practice in particular institutional contexts. The identification of functions common to all health educators working in all practice settings draws attention away from critical differences that cannot be ignored in determining the nature of quality health education performance. Diluted generalizations provide little guidance either for practitioners or for institutions preparing health educators to work in the real world of people, problems, and organizations.

Approaching standard-setting through the definition of a generic health educator role also neglects realities of how standards become accepted and implemented. A close appraisal of current accrediting mechanisms and those likely to be operative during the next decade offers little hope that standards for the professional preparation of health educators can be applied effectively through this channel. Prospects for enforcing health education standards in the field are likewise extremely dim except as institutions and agencies voluntarily set criteria for hiring and job performance.

Health education theory and practical experience provide ample evidence that those who are expected to act voluntarily must be involved both in analyzing the problem and in developing an acceptable solution. Nevertheless, by drawing together health educators from many streams of practice to define their common functions, the Role Delineation Project excludes organizational decision-makers and special interest groups from active participation in the standard-setting process. Both for this reason and because a generic role cannot reflect adaptation to the unique concerns and characteristics of specialized realms of practice, the standards developed by health educators acting ecumenically with each other, but in isolation from other sectors of society, are likely to find minimal acceptance and probably considerable resistance among those with standard-setting powers in medical care.

The Role Delineation Project rests upon the premise that the definition of common health education functions and a generic role will unify health educators working in schools with those working in other institutions and communities. Such unification, in turn, is considered important in increasing societal support for professional health education preparation and practice. In response to this argument, we suggest, first, that societal support for any profession is merited and won only to the extent that this profession demonstrates particular abilities to impact on significant societal problems. Second, while we agree that professional unification is important in obtaining greater societal support, we point out that role delineation is only one

approach through which unification can be accomplished. As indicated previously, the definition of a generic role directs attention away from the critical health problems that should be the focus of professional health education practice, because these problems differ in different practice settings. Moreover, role delineation leads health educators to devote their time and energy to internal professional concerns at the expense of their active involvement on the front lines of attack against society's ills. Neither society's problems nor organized efforts to control them will wait unchanged while health educators encapsulate themselves in a professional vacuum to define their common role.

These considerations lead us to conclude that our professional identity will best be forged and our professional practice advanced as we consolidate our resources to confront the major health problems plaguing society today and emerging to plague us tomorrow. Our roles will necessarily vary as we work from different bases to address different health needs in different population groups. Our unity therefore will not be found in role performance, but rather in our combined efforts to address massive social tasks, our philosophy, our values, and our commitment to achieving a healthier society through education. Medical care is one crucible in which societal change is occurring and in which we must get on with the job as part of a larger systems approach.

Credentialing: Implications for (School) Health Education

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My assignment is to present to you the concerns about credentialing from the perspective of school health educators. For me, the hardest part of this task is to view health education as separate programs for different settings. I think of myself as a health educator--not a school, community, or medical care educator. Nonetheless, for the purposes of this panel, I have tried to limit my remarks to the special concerns of health educators who work in school settings.

It may well be that credentialing raises fewer concerns for the professional preparation of health educators in schools than it does for the professional preparation of health educators for work in other community settings, including medical care. This is because there is a history of credentialing for elementary and secondary school teachers, who constitute the great majority of those intending to practice health education in a school setting. The traditional credentialing includes institutional accreditation, curriculum approval, program registration, and the licensing and certification of graduates.

For example, the institution providing the professional preparation may be accredited by the National Council for the Accreditation of Teacher Education (NCATE).

The Health Education curriculum itself may be reviewed and approved by a State education authority. Traditionally, programs must be registered with the State education authority.

The successful graduates of such programs are eligible for licensing as teachers and also for certification as health education specialists, in states where such certification exists.

Though there may be weaknesses in the processes for determining the extent to which standards have been met, there is no lack of credentialing. There are nonetheless some real concerns relating to credentialing for health education programs leading to professional practice in school settings. I will address myself to three of these.

1. The lack of uniform national credentialing for health education.

The type of accreditation provided by NCATE is institutional in nature. A participating university or college is reviewed and rated in terms of schoolwide standards and may receive institutional accreditation. However, there are no standards specific to health education. Professional preparation programs in health education may receive a cursory or a careful review by site visitors who may have minimal or extensive knowledge of the field. Accreditation by NCATE is therefore not evidence of an institution's meeting of standards that are specific to the field of health education. (This situation is similar to the schoolwide, rather than programmatic, reviews of schools of public health by the Council on Education for Public Health.)

There is a lack of uniformity in the way school health educators are prepared across the country. Universities develop their own programs, which differ considerably. This same lack of uniformity applies to the standards and approval procedures applied by State education authorities, who have the legal responsibility for education. Because the authority lies with State and not with Federal Government, there could be 50 different curricula for preparing school personnel for health education functions.

In fact, the wide variations of State requirements for professional programs have resulted in differences in range and depth of subjects studied, duration of the curriculum, nature and amount of field work, minimum competency, expectations, and the qualifications of faculty leadership. No only do the existing standards vary, but so does the monitoring process. Standards on paper are not necessarily those in

practice. Professional preparation of school health educators in the United States is not one, but many things. Though variation is not in itself a weakness, there is concern that health education leaders have the skills and knowledge to make maximum contribution to the education of the ultimate consumers: children and youth in schools and their families. At least minimum standards should exist in all states. And health educators should be able to have credentials that will enable them to practice in any of the states of the nation, a situation that does not exist at present.

2. The lack of uniformity in the basic professional preparation of entrylevel health educators, regardless of the settings in which they are preparing to work.

At present there is a proliferation of institutions of higher education providing entry-level (whatever that is) preparation of health educators. Currently, approximately 108 institutions offer baccalaureate preparation, and approximately 80 offer Master's programs. Traditionally, students preparing for teaching or other educational work in school settings have studied in schools or colleges of education.

Those preparing for health education in non-school settings have studied in schools of public health. Often there is little communication or collaboration among these units, even where they exist on the same campus. And, although there has been a growing agreement within the profession that there is a common core of knowledge and skills needed by any kind of health edcuator, the preparation continues to be separated, for the most part. This has created some obvious problems:

- A lack of uniform standards, uniformly applied;
- A lack of appreciation of the health education profession as a single profession, not several;
- The limitation of communication and collaboration among the different health education specialists during their training for a field that requires cooperative efforts;
- The misunderstanding on the part of the public, including employers, of what health educators are prepared to do.

The often competing professional preparation programs, professional health education organizations, and even government departments and bureaus have contributed to the lack of professional growth of the field. There is no single voice for the field, and there needs to be.

Because schools are part of the community, and school personnel usually view themselves as school/community professionals, it has been a natural occurrence for health educators prepared primarily for teaching positions to move into community (non-school-centered) health education jobs, either out of choice or out of a lack of teaching opportunities. Since there is no license or other special credential needed, this has been an easy transition. On the other hand, the movement by community health educators into school positions, especially teaching, is not as easy because there are licensing and sometimes certification requirements.

3. <u>The need for one basic curriculum to meet the entry-level credentials for school/community health educators</u>.

For the professional preparation faculty, the challenge is to provide an entry-level curriculum that prepares students for more than one setting. A few such curricula exist. Also, some institutions encourage the individual tailoring of professional preparation programs to permit students simultaneously to earn the community public health education credential and to fulfill qualifications for teaching health education. As the need for trained health educators in medical care settings expands and the standards for such specialization are defined and applied, there will be further concerns about proliferation of training.

<u>Concluding comments</u>:

In a very practical sense, my everyday on-the-job concerns about professional preparation of school health educators and community health educators, as well as several kinds of specialist (sex educators,

alcohol specialists, environmentalists), force me to deal with such issues as:

a. Explaining to administrators what health education is (and is not) and why they should support morally and financially the several curricula, the required State approvals, and several accreditation processes.

b. Dealing with several different accreditation groups; providing the faculty time for self-study, site visits, and follow-up, the extra secretarial time and patience; budgeting for ever-increasing annual fees and the special costs of the review process; and when it is all over, wondering whether accreditation is worth the effort.

c. Advising health education students and potential students about their choice of university, their choice of specialization, and their probability of employment in the area or areas they choose. Explaining accreditation and certification and their relationship to employment.

d. Teaching about the profession to students in training; interpreting the credentialing situation; and encouraging acceptance of the need for uniform standards, uniformly applied by qualified professionals. Encouraging a broad view of the field.

e. Determining in which professional health education organization to be most active during a given year; paying the dues of too many; and wishing our profession had a single "voice."

f. Intepreting the field to outsiders. Even health-related professionals do not understand what it is and what health educators do.

g. Searching, as an individual professional and as a member of a health education faculty, for a solution to the problem of defining across-the-board standards that will make it possible for health educators to be able to fulfill the potential of helping people at any age--in any setting--live healthier lives.

Will credentialing make a difference? Will it really have a positive effect on the achievement of our nation's health goals? Will it protect the public? That, of course, must be the ultimate concern.

Credentialing: Implications for Institutions and Programs

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Background and Definitions

Most people agree that personnel credentialing has a basic purpose of consumer protection. By licensing, certifying, or registering personnel, the public can recognize practitioners who have met certain educational and professional standards and are presumed to be competent to deliver services. According to the National Commission for Health Certifying Agencies (NCHCA), more than 100 health fields are regulated or seeking regulation by some sort of credentialing mechanism.(1)

If we are to consider credentialing and its impact on educational institutions and programs, we must consider it in relation to a number of quality control mechanisms that, together, make a significant impact. Four basic categories of activity designed to insure quality of educational programs and professional practice are:

- Accreditation of educational programs
- Credentialing of personnel--through licensure, certification, or registration
- Peer review of performance
- Continuing education.

1. First, let us look at accreditation. Accreditation is "the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined standards....Accreditation is usually given by a private organization created for the purpose of assuring the public of the quality of the accredited (such as the Joint Commission on Accreditation of Hospitals)...."(2)

The impact of accreditation on educational programs is quite direct. Accreditation provides peer review of and influence on what should be in the program--its curriculum content and sequence, qualification of faculty, availability of facilities and resources, educational support services, and the like. For each program "essentials" (or minimum standards) are developed; faculty assess their own programs in light of the essentials, using a self-study process; peers from similar programs and institutions conduct site visits and evaluations, based on standards contained in the essentials. Graduation from an accredited educational program is normally a prerequisite for eligibility to take a credentialing exam and thereby enter into practice.

2. Credentialing of personnel is "the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership or the award of a degree in the field....Credentialing also determines the quality of personnel by providing standards for evaluating competence, and defining the scope and functions in how personnel may be used."(3)

a. Licensure is "permission granted to an individual or organization by competent authority, usually public, to engage in the practice, occupation or activity otherwise unlawful...."(4) Licensing is the most restrictive form of occupational regulation because it prohibits anyone from engaging in activities covered by the scope of practice without permission from a government agency. There are a number of health occupations and professions covered by licensing laws in one or more states--including audiologists/speech pathologists, chiropractors, clinical laboratory personnel, dental hygienists, dentists, dietitians, emergency medical technicians, medical technologists, licensed practical nurses, registered professional nurses, nursing home administrators, occupational therapists, optometrists, pharmacists, physical therapists, physicians, psychologists, radiologic technologists, respiratory therapists, sanitarians, social workers, veterinarians, and others.

b. Certification is "the process by which a governmental or nongovernmental agency or association evaluates and recognizes an individual, institution, or educational program as meeting predetermined standards. Essentially it is synonymous with accreditation, except that certification is usually applied to individuals and accreditation to institutions. Certification programs are generally nongovernmental and do not exclude the uncertified from practice, as do licensure programs...."(5) Shimberg, in a recent paper on "National Developments in Health Occupations Credentialing," explains both governmental and voluntary certification processes. He points out, "For example, in many states anyone may practice accounting, but only those who have met State standards may call themselves 'Certified Public Accountants.' Unlike licensing, the law does not prohibit non-certified individuals from engaging in specified activities; however, it does prohibit them from using a given title or from holding themselves out to the public as being 'certified.'"(6)

One interpretation of the difference between licensure and certification is that licensing is concerned primarily with safe/unsafe practices, whereas certification deals with differentiating the excellent from the good. In voluntary, i.e., nongovernmental, certification, many professional and trade groups grant recognition to individuals who have attained certain entry levels or are qualified in special areas of practice or have superior competence in given occupations. Shimberg points out that while all physicians must be licensed by the State before they can practice, those who meet standards set by nongovernmental certification agencies may be recognized for their competence in various fields of specialization. Hence, various specialties of medicine have their specialty boards, which voluntarily certify physicians who pass examinations and meet other requirements. At present there are 23 medical specialty boards, none of which are based on any law. They represent a voluntary effort on the part of occupational groups to grant recognition to those who have achieved a required degree of knowledge and skill in a given field.(7)

c. The third form of credentialing is registration. It is "the process by which qualified individuals are listed on an official roster maintained by a governmental or nongovernmental agency. Standards for registration may include such things as successful completion of a written examination given by the registry, membership in the professional association maintaining the registry, and education and experience such as graduation from an approved program or equivalent experience...."(8) Registration is used in situations where the threat to public health safety or welfare is minimal. It should be noted that although some disciplines are called "registered," as in Registered Nurse, they are, in fact, licensed.

Any group can set up a certification process and set standards in the non-governmental sector. In fact, there are so many certifying bodies in the health care occupations and professions that recently (1976) the National Commission for Health Certifying Agencies (NCHCA) was organized to develop standards for recognition of health certifying agencies--in other words, to "accredit" the certifying agencies. According to the NCHCA, there are more than 100 health certifying agencies. Currently, approximately 45 different occupations in the health field are regulated, 14 of them in all states.(9)

3. Peer review is a third quality assurance mechanism, primarily utilized in the medical sector at the present time. Public Law 92-603 authorized development of Professional Standards Review Organizations (PSRO) primarily for reviewing utilization of certain government medical care programs such as Medicare, Medicaid, and child health services. At present, peer review of professional performance is not widely utilized by allied health disciplines but is being studied for applicability as a quality control mechanism for future utilization.

4. The fourth quality assurance mechanism is continuing education. Continuing education is often tied in with continued certification to assure additional study toward updating competence and proficiency. Many of our professional disciplines are beginning to mandate continuing education for continued recognition and recertification.

Several groups, such as medical record administrators and dietitians, mandate specific clock-hour requirements of continuing education over a period of time. Failure to maintain these requirements results in loss of certification.

Unfortunately, the groups mandating continuing education often cannot specify continuing education for what. Ideally, one should know the level of knowledge, skills, and behaviors demanded by advancing technologies and practice and should base continuing education (or any other learning mechanism) on making up the difference between the "is" and the "ought." Until we tie continuing education with specific knowledge and skills required of the profession, we are likely to be spinning our wheels in that continuing education offerings may not be related to specific advanced knowledge, skills, and competencies required. What good, for example, is a continuing education course in Financial Management for the physician? It may be good for him or her as an individual but does not extend his or her skills as a practitioner.

But the fact that our state of the art in coninuing education is imperfect should not negate our recognition of continuing education as an attempt at quality control and continued competence.

Processes and Issues

Let us go back and examine the process of developing credentialing standards and procedures. First, we must start with a baseline of knowledge, skills, and behaviors or competencies necessary in order to practice the discipline (i.e., minimum standards for getting the job done effectively). Second, these standards must be translated into reliable and valid tests that can evaluate the extent to which the individual measures up to these standards. Third, a system should be developed of recognition of the individual who measures up to the standards of excellence of the discipline.

There are several issues in credentialing. One of the weaknesses of voluntary certification is the absence of standards. Any group

wishing to establish its own certifying agency is free to do so. Often in the past, as a group moved toward professionalism, it would organize a national association, which would then set up an accreditation organization for program accreditation and a credentialing organization for individual recognition. Usually these organizations would be part of, or closely related to, the professional association, a situation leading to claims of conflict of interest. For example, until a few years ago the American Speech, Language, and Hearing Association mandated membership in their professional organization as a precondition for eligibility to sit for the certifying exam. This was ultimately challenged in courts and the court ruled against the Association, so that membership in the Association is no longer related to the certification process.

Recently the Federal Trade Commission (FTC) and others have been accusing some of the health professions of being so self-interested that they are fostering restraint of trade. We realize the same mechanisms that are designed to assure quality of care can also be used to control numbers of people in the profession, restrict competition, and have certain economic spin-offs. Recently FTC challenged the dental profession about whether or not dentists are restricting trade in controlling the practice of dental hygienists through dental practice acts in each state. This issue, therefore, involves the legitimacy and the public interest of the credentialing agency. Is it in the public interest to have a special interest group be its own judge and jury? Generally the professions say "yes" because they believe that nobody else is capable of judging their competence. Others, however, are focusing on alleged conflict of interest.

Another issue relates to prerequisites for taking credentialing examinations. Eligibility to take credentialing examinations in most health professions normally excludes those who did not graduate from programs accredited by the recognized national accrediting agency. This raises the issue about learning that takes place in nontraditional settings--on the job, self-learning, military programs that do not meet

civilian accreditation standards, and the like. In addition, there are conflicts among organizations about claims to accredit programs, as has been exhibited by the conflict between the American Physical Therapy Association and the Committee on Allied Health Evaluation and Accreditation (CAHEA). Both organizations seek to be the recognized national accrediting body. Consequently, some of us have physical therapy educational programs accredited by both groups, pending resolution of the conflict.

Implications for Programs

What does all this have to do with implications of credentialing for institutions and programs? Credentialing has a direct impact on practitioners and the occupations or professions in that it influences their ability to practice as individuals. Educational institutions judge programs to a certain extent on how well their graduates perform on the credentialing examinations. We can compare our performance with other, similar schools and programs in terms of the percentage of candidates passing on the first attempt or on examination scores. Usually, if a graduate fails, we can identify areas of weakness and examine our curricula and instruction in those areas. Indeed, one of our own college objectives is that all our graduates pass the particular credentialing exams on the first attempt. A second objective is that our graduates will exceed national and regional averages on credentialing examinations.

Feedback from credentialing examination results represents one kind of external evaluation. It lets us know how our students perform as compared with students from other programs. Whereas accreditation provides prospective evaluation focusing on process, credentialing examination results provide retrospective feedback on the product.

My major observation, however, is that one must consider accreditation, certification, and other quality assurance mechanisms together. They influence one another; hence, they influence educational programs collectively. I would like to mention, however, that accrediting and

credentialing standards represent minimum acceptable standards; educational programs strive to achieve much more than minimums.

Health sciences may be unique in the rapidity of technical change and its impact on manpower requirements and needs. For each new technique comes a new specialty--for example, with rapid developments in ultrasound, we now have a relatively new discipline called "diagnostic medical sonography." The new group is working with the Committee on Allied Health Evaluation and Accreditation (CAHEA) to develop essentials for accrediting programs. With that as a newly recognized discipline and with "essentials" for accreditation, credentialing procedures will follow for individual recognition. All these events will influence the eventual curriculum design of programs to prepare the sonographers.

Implications for Health Education

How does health education fit into this kind of schema? Assuming you want to recognize those health educators who are appropriately prepared and meet certain standards of excellence, then you may wish to develop a credentialing process. With the current state of the art, I would argue against licensure as a form of credentialing for health educators. I would recommend that you avoid the restrictions of licensure in that licensure would exclude those who are not licensed from practicing the discipline--and that would be quite impossible if we tried to exclude the many people who are working in some aspect of health education. I would argue for a voluntary system of certification for health educators--recognizing those who meet certain defined educational standards, knowledge, skills, and competencies--but not precluding others from practicing (see the analogy to Certified Public Accountants, mentioned previously). Such a system would guide potential employers to choose preferentially one who is recognized by the professional "seal of approval."

The National Center for Health Education, through its Role Delineation Project, has made a good start by identifying the skills, knowledges, and behaviors expected of a health educator. This could be

the framework for setting the standards that stress excellence and developing the measures to evaluate those wishing to demonstrate their excellence via the certification process.

Failure to meet standards would not necessarily deprive individuals of the opportunity to work, but it might prevent such individuals from getting the best jobs. This, then, would provide an incentive for practitioners to seek additional education, training, or experience in order to meet the group's certification requirements. It also would help employers to evaluate an applicant's credentials. There are possible future implications toward arguing for third-party payment for services rendered--assuring the third-party payer that a qualified individual (i.e., certified) rendered the services.

As pointed out in the National Commission for Health Certifying Agency report, the challenge will be to design appropriate test instruments that effectively measure skills, knowledge, and professional attributes deemed essential for competent practice. In some credentialing exams, individuals have challenged the validity of tests on the basis of a lack of job relatedness.(10) There is another problem in defining the domains of the subject to be assessed in implementing appropriate test mechanisms.

Usually, credentialing exams are written (paper and pencil) to reflect measures or levels of academic performance, and usually, these exams are process-oriented rather than outcome-oriented and normally do not measure such attributes as interpersonal effectiveness or motivation.

In some cases, practical examinations are given; an example is dental hygiene and dentistry, where the graduates perform clinical procedures and are evaluated by experts. The problem with practical examinations is that of cost and difficulty in administering the examinations.

Needed also are equivalency and proficiency examinations that measure the ability to do the job (proficiency) and measure learning

that has emanated from nonformal educational programs (equivalency). An example of the need for this is placing graduates of military educational programs into civilian programs or testing them for certification in the civilian sector.

There are two kinds of system for evaluating examination results: norm-referenced and criterion-referenced examinations. The norm-referenced examinations identify the relative standing of all people taking the examination--in other words, grading is on the curve, with the pass/fail threshold usually being one standard deviation below the mean. In norm-referenced examinations, you are assuring that there will be failures--i.e., below one standard deviation.

Many of the health fields are now converting to criterion-referenced examinations, which grade according to a certain score. These examinations require well-defined domains and criteria for pass or fail. First, one must define the abilities, knowledge, skills, and other attributes; and performance standards must be set. Pass/fail scores must be set. Some disciplines may set their scores unrealistically high or low--it is possible for all to pass or none at all. It is helpful to engage the assistance of psychometrists, who are skilled at test construction and evaluation.

Criterion-referenced examinations can be developed by a panel of experts to outline essential competencies in the particular discipline, or one can start from a basis of task analysis--making observations regarding actual job performance in order to identify the essential elements of the discipline.

Another thing to consider is whether the standard for pass/fail should be based on the entire test or whether the test should be divided and graded in subparts, each with a pass/fail cutoff point. For example, our physical therapy examinations have three parts, each with a pass/fail mark; hence, a graduate may fail one of the three parts but will not have to take the entire examination over. This system also

provides feedback for the educational program in terms of areas of strength and weakness in the curriculum.

Scope of Practice/Role Delineations

One of the major purposes and effects of credentialing, as pointed out in the NCHCA report, is to delineate the scope of practice of each regulated profession.(11) Typically, this occurs through licensing statutes and voluntary certification procedures. The delineation of scopes of practice is becoming increasingly important (role delineations) with the proliferation of professions and specialization within professions. As changes in health care delivery systems mandate changes in scope of practice, some statutory definitions become outdated or are inflexible or oppressive. Very often these definitions and scopes of practice overlap one another. For example, the NCHCA report analyzes the lack of clarity of roles among psychiatry, psychology, and social work scopes of practice.(12) This may complicate credentialing processes if several groups of practitioners lay claim to overlapping roles or scopes of practice.

Summary

Four mechanisms can be identified that are designed for assuring quality and competence of personnel, hence, consumer protection. They are: accreditation of educational programs, credentialing personnel, peer review of performance, and programs of continuing education.

I would like to recommend that health educators start from the results of your Role Delineation Project, in which the scope of practice is quite well defined. Among credentialing mechanisms, I would recommend that you opt for a voluntary certification process that will recognize those with the educational backgrounds, knowledge, skills, and behaviors required for ethical health education practice. Next, utilize experienced psychometricians for assistance in the construction and validation of appropriate credentialing examinations. Organize a group to implement the certification process, and link up with the National Commission for Health Certifying Agencies for assistance in developing guidelines and procedures.

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Options and Opportunities: Recommendations for Future Action

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Introduction

The original planning for this event indicated that at this point in the conference, we would need a transition--something that would move us from deliberation to action; something that would move us from problems to developing specific steps to solve problems; something that would help us move from possibly vague anxieties about credentialing to perhaps more specific anxieties that can be addressed and dealt with; something that would open up the future to opportunities rather than narrow it down to limited alternatives; something that would move those of us who might be reluctant to take the next steps so that we will be willing to venture into the uncharted future and to become somewhat more crusaders for credentialing; something that would light us on fire, to help us "get our act together" as faculty members in institutions that have as their goal the preparation of the finest possible health educators we can prepare. This transition will hopefully move us in some of these directions, although it is possible I have "canceled myself out" by trying achieve too many objectives in such a short time. It appeared to us in the planning stages that the task for this session would be to both "calm the troops" and "incite them to riot," depending on how the conference was progressing; to both encourage specificity if we were getting too vague and encourage generality if we were getting down too far to the "nitty gritty"; and to encourage vision if we were looking only toward tomorrow, but to encourage short-term concerns if we were postponing action by looking too far into the future.

The title of this part of the conference program, "Options and Opportunities: Recommendations for Future Action," is meant to imply a number of things: (1) First, it is meant to suggest that we do indeed

have options for the future--we have options to reject or to support the Role Delineation Project now or in its later stages; we have options as individual faculty members, as faculty members acting jointly with our academic colleagues, and as individuals who are members also of professional organizations and other groups. (2) Second, the title is meant to imply that there are indeed opportunities--opportunities to improve the status of the profession, opportunities for our graduates to achieve national health goals, opportunities, if you will, to continue our "becoming," as Gordon Allport would have called it--"becoming" as a profession. These opportunities may have always been around, but now we have the stimulation of the Role Delineation Project to help us. (3) Third, the title is meant to imply that recommendations are sought, sought by the Task Force guiding the project and sought by the agencies that have assisted in its implementation. But beyond these concerned groups, in truth, we, as representatives of academic programs, may also be seeking recommendations. Because we have not had an effective way of dealing collectively with the problems of credentialing as educational institutions, we must sometimes deal with intermediaries and use less direct ways of planning how to proceed as educational institutions. (4) Last, the title is meant to suggest the need for future-oriented recommendations. As in all ventures of this kind, it is probable that each of us would have had suggestions for alternative ways of listing responsibilities, functions, skills, and knowledge. Some of us may have had input into the project; others may not. In any case, we cannot go back. It is time to go forward; and we are looking forward to hearing future-oriented recommendations in the next group discussions, based on your view of the overall project and the steps planned.

As we approach the task of making recommendations, it seemed to the planning committee that we needed a focal point for the recommendations. Rather than make recommendations to many different individuals, groups, or organizations, we thought it more effective to deal directly with the group most involved to date. We are requesting, therefore, that the recommendations be formulated in such a way that they can be actions the National Task Force can take. This procedure is not designed to prevent you from making recommendations to other groups, for it is possible to

suggest that the National Task Force either initiate action or implement action. But by having the members of this group as the focal point, we are assured that there is a responsible group present that can, at a minimum, take the first steps to get things moving, even if another group or groups are to be involved subsequently.

As we think about recommendations to the National Task Force, it is possible to see the Task Force as an action group (taking action on the recommendations that may fit as a part of their current charge); as a stimulator (encouraging other groups with charges or available opportunities that would indicate they could move more appropriately or effectively on given issues); or as a clearinghouse (moving communications as needed among the different groups).

Contextual Framework for Recommendations

Our approach to making recommendations will be dependent upon so many things--our agreement or disagreement with what has been done; our understanding of what lies ahead; our views of the so-called generic health educator; and our views of a host of other things that are included on the flow chart describing the several major steps involved in the Role Delineation Project.

Further, our discussions and recommendations are not taking place in a vacuum, and all of you can think of some of the forces at work, both positive and negative.

I would like to suggest, however, a few contextual issues that have particular relevance to those of us from education institutions. Let me just mention a few.

The Time Line

For many of us, there is a need to place the credentialing process on a flow chart and on a realistic time line in order to see what "crunch" or "crunches" may be ahead in terms of allocating personal, organizational, and financial resources. It would not be at all unrealistic, in my view, to see a decade or more required from beginning to

end of the two major lines of development in Alan Henderson's flow chart, ending in the final "arrival" of the first credentialed entry-level health educators.

Some of us may be looking forward to retirement, so we do not have to worry. Others of us may decide to take early retirement to avoid facing the problems. Still others of us are going to have to cope with the problems, and I hope there are going to be enough young faculty in strong programs to carry the academic part of this projected load.

If one accepts the frequently heard proposition that the half-life of a professional curriculum is five years, we can see that during the development of this project, if this all happens within ten years, we will have only one quarter of our current knowledge base intact by the end. This fact alone would require, therefore, an enormous amount of networking and communication among the parties involved, particularly the educational institutions, to keep us all moving somewhat together and to keep us all current.

"Freezing" or "Unfreezing"

Another sort of situation that may be confronting some of us is a concern that evolves not only from the curriculum half-life problem but also from the problem of changing roles and practices. The statement that has evolved from the Role Delineation Project to date probably would not have been the same if it had been developed ten years ago. Likely it would not turn out to be the same if the statement were to be completed ten years hence. Therefore, a question arises about building changes into the plan, thereby assuring the profession that it still is open-ended, growing, expanding, and being increasingly creative. In this light, therefore, some of us may be wondering whether we are going into a stage that Lewin called "freezing" or whether we are truly moving into an "unfreezing" stage. Whether you believe we are moving into one or the other as a consequence of the work on credentialing will partially determine how you approach the recommendations for action.

Perhaps some may see us "freezing" the profession--by seemingly closing off options for expansion, broadening, or altering roles and responsibilities and by making what seems to be a hard and fast statement at this time. On the other hand, perhaps some will see us "unfreezing," by breaking down specialities, by developing a generic view of the profession, and by continuing the creative interorganizational dialogue that was begun in earnest with the Coalition of National Health Education Organizations. Perhaps we are "freezing" by putting in place all the structural elements required for professional development. On the other hand, perhaps we are "unfreezing" by getting some of the groups together--like the academic programs--and helping them increase their intercommunication and collaboration. Maybe we are doing both simultaneously. You will have to decide from your own unique view whether you see us moving one way or the other, the values that are enhanced or lost as a result, and how these factors will affect the future.

"Coming of Age" and Accountability

I am not sure that if each of us could have dreamed his or her wildest dream for the profession, we would have picked the goal of credentialed entry-level health educators as an end point. Rather, I suspect we would have placed emphasis on something like a health educator in every health agency--like a chicken in every pot--as a goal. Or perhaps we would have said we do not care about all the professional paraphernalia; rather, we are concerned about what happens to people in the community or kids in the schools. Are they any better off because we as a profession are there? Or is our society any better because we are there? Just a little better? Some of us, then, may perceive the organizational steps in development of the profession as irrelevant, or at best, a necessary evil.

In truth, I think most of us would wish for an idyllic world of only moderate accountability. Unfortunately, that kind of world does not exist and will not exist in the future.

Whether we like it or not, we must respond to outside societal pressures, and accountability, quality control, and self-regulation are part of the demands placed on us as the price of "coming of age" as a profession.

Appropriate Academic Concerns

Another contextual issue I would like to raise is the relationship of academicians to the credentialing process. In a major document prepared for the National Forum on Accreditation of Allied Health Education about a year ago, John Schermerhorn found most educators feel strongly that the educational institution is not the proper arena for the upgrading of professional practice. Rather, it is the responsibility of the professional society and its membership. The educational institution, then, must be responsive, within its capabilities, to the needs of the professionals, the employers, and the public; and it must not be forced, by any means, to take positions in support of any one group at the expense of others. I found this a perplexing statement, since those of us who teach practitioners have ourselves been intimately linked with practice at one time or another in our lives, and most of us belong to the same professional organizations as practitioners do--indeed, we are often the same group. What makes us different as academicians in response to issues of credentialing?

Should we respond at all to role delineation, role specification, and all the rest, or should we simply wait until the profession tells us what it intends to do, and then respond within the limits of our academic world? Our being here would suggest we see a more active role for ourselves. Up to this point, however, we have not had an organized way to respond as academic institutions. Some of us have participated through representation on the various committees and task forces in the whole development of the project, but as someone in the Towson State meeting said in December last year, "There is a definite overrepresentation of academicians in the Role Delineation Project." Is it time to rethink this issue? If we should be responsive to the needs of <u>professionals</u>, <u>employers</u>, and the <u>public</u> without supporting any group, and yet we are so identified with professionals because we are they, and they

are we, how can we be responsible to the needs of employers and the public as effectively? As most of us know, credentialing has been criticized by many as being protective of the profession instead of the public. Will we contribute to that professional protection at the expense of our other responsibilities? Some hard thinking on the responsibilities of academic institutions and their faculties is needed on this point.

Some Emerging Process Issues

It has seemed to me, as I listened in our own group discussion, and as I had a chance to talk with participants and faculty, that a number of what I have called "process issues" relating to our consideration of recommendations have arisen. Let me list just a few--clarity, anxiety, diversity, and solidarity--and deal with each briefly.

Clarity - clarity of where we want to go. We were challenged, I believe, by Salman when he asked us, "Where is it you really want to go?" This question asks us, then, to decide where we want to be as a profession, say, in 1990. How healthy (as a profession) do we want to be in 1990, if I can use an analogy from the document Healthy People? Do we want more programs to prepare health educators? Do we want better programs preparing health educators? Do we want more capable graduates? More political clout? More access to resources? Do we want to make a contribution to achieving the health Objectives for the Nation? Or do we want to achieve greater coherence in our joint missions? We have been encouraged, also by Salman, to "avoid mixing the ideal with the actual." How then do we handle short-term and long-term goals--the here-today reality with the tomorrow ideal? Helen Cleary mentioned how important it is for us to define action steps for the here and now--like, "What do we do when we go back home to help in the Role Delineation Project or Role Verification stage of that project?" We all know, however, that what we do next must also be seen within the framework of where we want to be "in the long haul."

Anxiety - I am aware, as most of you are as well, that while we have been working together, a number of people have admitted that they

were more than a little concerned about this entire development. Some participants may have been threatened by the credentialing process, and some have openly admitted it. Someone said to me, "I am frustrated by this meeting, but I am feeling better now because I can now at least understand the jargon about credentialing." Someone else said, "I do not know yet what I think in order to make recommendations, because I am still confused and do not have enough data about what the future holds for me and my institution if credentialing emerges as an important force. The full consequences or the relative costs of taking one or another step next are not clear, and I am anxious about committing myself to a specific recommendation right now."

I also sensed that some participants may be wondering whether their programs and/or their specific jobs may be in jeopardy. Perhaps they are feeling, "Suppose someone decides I am not needed, that my program is not needed, or is not adequate?" These anxieties are real, and I think we must acknowledge them in order to work effectively together. People have been confused by all the jargon involved in credentialing; people have been placed in ambiguous situations because the outcomes in the future of the decisions made today are not all that clear; people have been honestly threatened by the possibility that some new standards and criteria for assessing their programs will emerge, and hence, they themselves may be rated "below standard." These ratings may carry with them the apparent judgment that the program should be abolished if there are insufficient resources to upgrade it to meet standards. These feelings will not disappear readily. We should acknowledge that they exist and try to deal with them openly.

Diversity - Those of you who remember Dorothy Nyswander's magnificent article on the "open society" will recall she stated that one of the major requirements for an "open society" was the support for diversity in the population. I hope, as we move towards some commonalities in our concerns for a generic health educator, we will consider the possibility that we may be moving ourselves toward a "closed society"--meaning a closed professional society. Yet we have people in our midst who are marching to the beat of a different drummer, and there may be a

temptation to throw them out or at least avoid them or ignore them. To me, this would be an absolute disaster for the profession. Without constant criticism from individuals inside and outside the profession, it will not be possible for us to grow. I hope we will always have individuals who can play the role of "Her Majesty's Loyal Opposition" to remind us of the need for change and the need to look at ourselves critically. We are fortunate that some of those individuals are here at this meeting.

Solidarity - Even the word "solidarity" has a special ring these days. It was clear from the presentation of Ray Carlaw that we need more solidarity; it was clear when Marian Hamburg told us that we did not speak with a single voice as a profession; but it was also clear in several of the discussion groups that we were, indeed, a "family" of institutions. We all have recognized the need to speak with a more united voice. The Coalition of National Health Education Organizations, which some of us helped to start in the early 1970s in response to the President's Committee on Health Education, has played a significant role in bringing the different factions of the profession into a more collaborative arrangement and in increasing the communication among groups with some divergent interests. I think, however, most of us recognize that the Coalition was just a first step, and that much more collaboration and eventually unification will have to occur.

Some of us have thought, too, about the need for more solidarity among the university programs themselves, for we have not had a unified way to respond to credentialing or, for that matter, a unified way to respond to anything. Should there be an association of university programs in health education? Should we have some regional networks of university programs? Should there be an organizational arrangement that brings us together to talk about mutual problems, other than our chance meetings at professional conferences and conventions? What will the advantages and disadvantages be of some more organized arrangement among us? These and a host of other questions emerge as we consider our own solidarity.

Achieving Health Objectives for the Nation

A major challenge for us here has been to review the national health goals and to determine where we fit as academicians and as health educators in working towards those goals. We have discussed in our small group meetings how we would attempt to articulate credentialing goals with national health goals, and I think most of us recognize there is enough in the document Objectives For The Nation to keep us meeting and working for years. We do not have time, however, just to talk about them; we must act soon. The groups will likely find many areas here that lend themselves to recommendations. Certainly, many of us see ways to incorporate components of that document into our teaching programs. Certainly, every student graduating from our programs should be familiar with the contents of the document. Certainly, we must demonstrate within a reasonable time how we can contribute to achieving national health goals. There are many specific suggestions in the document for research, documentation, and program development. The document, however, has not been written for our benefit as health educators--it is a "mandate" for the public health movement, and each health discipline will attempt to chart out specific areas for itself. What, then, will be the areas we concentrate on and how should we begin?

Looking Toward the Future

While it is probable that much of our focus has been on the document, in truth, it is time to think beyond the Role Delineation document and the Role Verification stage as well. No matter how it comes out, there will be opportunities for change. More important, in my view, are the stages that follow and the tremendous amount of work that must go into them. If you follow, on the flow chart, only the early stages forward of credentialing, you can see that indeed, the major work lies ahead.

As you move to Phase III, for example, and note that an educational resource document is to be prepared, it is clear that this document begins to set the standards for preparation, particularly the curriculum requirements in our institutions. If the document is not to be endorsed by the various professional organizations listed, i.e., AAHE, ACHA,

APHA, ASHA, SOPHE, SSDHPER, and STDPHE, what role will the institutions of higher learning play in the development of these standards? Do we wish to speak with one voice? With several voices? Do we ally ourselves with one or more professional organizations and let them speak for us, or will we speak for ourselves as academicians?

If, on one hand, we decide to stay out of the fracas, because we would be acting as judge and jury, what do we do when the standards for preparation arrive at our doorstep? We are provided with an opportunity for voluntary adoption. Is that the step we want to take? Or do we want to encourage accreditation, especially when we recognize all the forces operating against individual program accreditation? Administrators and faculties in colleges and universities are increasingly annoyed with accreditation procedures, expense, and logistical problems, with very few perceived benefits.

It appeared to me, as I listened to our speakers and as I have had a chance to read the literature on professional competency, that we are going to be increasingly pressured to prepare health educators in competency-based programs. The Federal Government is not providing its largesse because it is intrigued with the peculiarities of professions grappling with this part of the accountability question. It has an investment in assuring that quality health personnel are prepared, that there are objective ways to assess those personnel, that entrance and exit competencies are assessed, and that continuing competence is maintained. If the professional groups approve of standards, the competence leading to those standards will turn out to be our responsibility.

As one follows the development of competency-based programs, one finds eventually the profession is asked to explain why the competency is listed anyway. While it may be accepted because it was verified by practitioners, someone is going to ask, for it has been asked of all professions, "How do you know, when this function is performed, what the relationship is between the competency and the performance?" More important, they will ask, "How do you know that the performance of this activity leads to any of the several outcomes?" Given questions like

these, who, then, will provide the basis for the testing and measuring of the validity of competence statements? It would not surprise me if we as academicians will be expected to play a major role. Some questions to ask ourselves are, "How ready are we to develop and teach competency-based programs for preparation of health educators?" "How able will we be to measure those competencies on exit from the program, and on admission to the program?" "How do we know the program makes any difference?" and "How do we know that performance on the job at a competent level is related to successful outcomes?" I can assure you that we will be in very good company, for no other profession has yet validated its performance in relation to outcomes. Surely that is no reason, though, for us to wait for someone else to do it first.

Further down the road may come "National Health Education Boards," in which we will all have a chance to see how our graduates do, especially in comparison with one another. Then we will be asked, "Why do these differences occur?" and "Is the performance of the student on the 'Boards' related to how well he/she actually does on the job?"

As I look at the opportunities and options along the way, it appears to me that we can get actively involved, stand by in a "holding pattern," or ignore it all. What is urgent, however, is the need to consider the arrangements by which the academic programs will relate to each other during these next few years, as competency-based programs are required.

Young Faculty and The Future

I have been very much impressed with the numbers of young faculty members who have been able to attend this meeting. Those of us who are now into or close to the senior citizen ranks in health education are grateful for the contributions these younger faculty members have made here. It may appear to some that the "old-timers" hold the power and that the younger faculty must defer to them. In truth, the future belongs more to the younger faculty members than to the "old duffers," and it is the job of all of us in academic institutions to provide effective ways for young faculty members to help chart the future of professional preparation in health education. I would want to see as

many assistant professors and associate professors as possible on the various committees planning our future.

Some Areas to Consider for Recommendations

As I have listened here to what everyone has said, it seemed to me we would have suggestions and recommendations in a number of areas, for example:

(1) Those that relate to the present Role Delineation document itself, its formulation, and its wording, particularly as it is related to the next step in the Role Delineation Project.

(2) Those that relate to the stated specific next steps in Role Verification, and that involve consideration of additional steps, or alternative steps that someone may consider more effective or more useful to the extent that they are possible within the framework of the conference.

(3) Those that relate to the entire Role Delineation Project and all its planned steps, not just individual steps but, rather, the whole process--its time constraints, its mechanisms to accomplish certain objectives, or its resources.

(4) Those that relate to our roles as academic institutions and as individuals or collective faculty members in those institutions, concerned with the preparation of health educators not only in relation to the next steps but, more important, to the long-term implications.

(5) Those that relate to the large issues in credentialing that need to be considered at some point in time and to which many of us individually and collectively, as either academicians or professional health educators, have to respond in the future.

About each of these categories, it seemed to me, the National Task Force wants to hear from us.

We have come a very long way in this conference in a very short time. The time has been right for our meeting together; the conference arrangements have been superb for our making the most of our time together; and the group assembled has a wealth of knowledge and skill in the major topics being discussed. Let us now see how we can put this all together in specific action recommendations.

Appendices

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RECOMMENDATIONS

WORKSHOP ON COMMONALITIES AND DIFFERENCES

Conference on the Preparation and Practice of Community
Patient and School Health Educators

February 15-17, 1978
Bethesda, Maryland

RECOMMENDATIONS

WORKSHOP ON COMMONALITIES AND DIFFERENCES

CONFERENCE ON THE PREPARATION AND PRACTICE OF COMMUNITY PATIENT AND SCHOOL HEALTH EDUCATORS

The participants presented recommendations for the future direction of health education in relation to preparation and practice of the total field, regardless of practice setting or speciality focus. These recommendations represent consensus on the part of the group and were viewed as positive action oriented steps to achieving a unified and acceptable approach for examining the preparation and practice of professional health educators.

RECOMMENDATIONS

- That each member organization of the Coalition assume responsibility for disseminating the proceedings of this Workshop. And that each group identify the implications of this Workshop for its own membership and explore the resources that it can commit to achieving the necessary follow-up to the Workshop.

- That the Planning Committee for this Workshop become a National Task Force on the Preparation and Practice of Health Educators. And that members of the Planning Committee continue to serve on the Task Force, subject to approval by the Organizations they represent.

- That the Task Force, including a representative from the Office of Education, be charged with the responsibility for developing a plan of action leading to a credentialing program within a specific time frame for the total field of health education. Specifically, the Task Force will:

  - serve as a liaison with health education organizations, and with pertinent government offices, including the Bureau of Health Manpower, and the Bureau of Health Education

  - establish priorities

  - seek funding to support a credentialing effort

- That the plan of action developed by the Task Force lead to:

  - a survey of field practice including a synthesis of existing research

  - a concrete statement of the State-of-the-Art of health education

- an assessment of health educator competencies
- development of performance criteria
- delineation of performance criteria
- delineation of core curriculum requirements for both entry level and specialized health educators

That government programs and private agencies with health education components require staffing by qualified health educators.

*February 15-17, 1978, Bethesda, Maryland

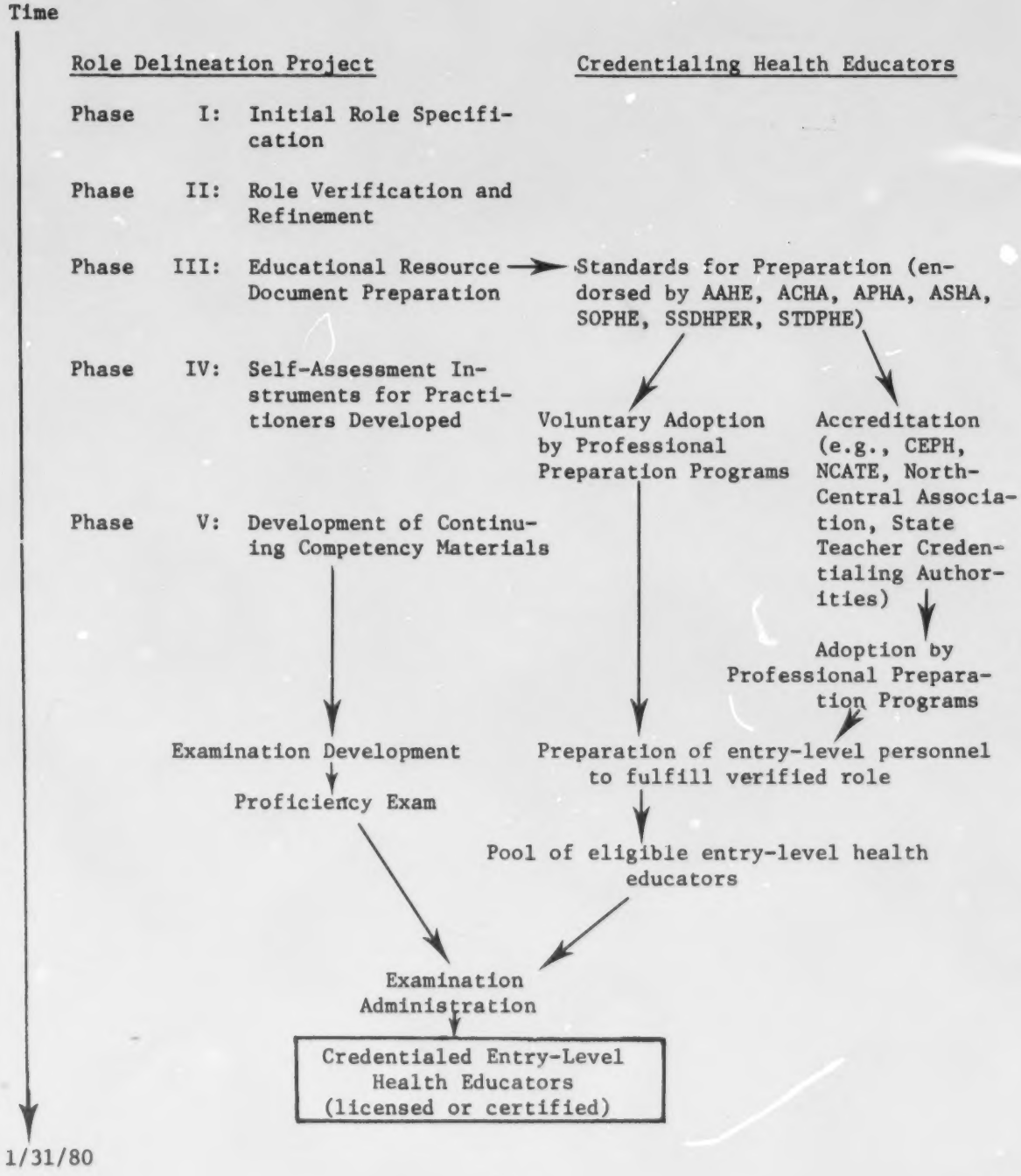
NATIONAL CENTER FOR HEALTH EDUCATION

ROLE DELINEATION PROJECT FOR HEALTH EDUCATION

National Center for Health Education

ROLE DELINEATION PROJECT FOR HEALTH EDUCATION

Relationship Between the Role Delineation and Credentialing Processes


Time
Role Delineation Project
Credentialing Health Educators
Phase I: Initial Role Specification
Phase II: Role Verification and Refinement
Phase III: Educational Resource Document Preparation
Standards for Preparation (endorsed by AAHE, ACHA, APHA, ASHA, SOPHE, SSDHPER, STDPHE)
Phase IV: Self-Assessment Instruments for Practitioners Developed
Voluntary Adoption by Professional Preparation Programs
Accreditation (e.g., CEPH, NCATE, North-Central Association, State Teacher Credentialing Authorities)
Phase V: Development of Continuing Competency Materials
Adoption by Professional Preparation Programs
Examination Development
Preparation of entry-level personnel to fulfill verified role
Proficiency Exam
Pool of eligible entry-level health educators
Examination Administration
Credentialed Entry-Level Health Educators (licensed or certified)
1/31/80

CHRONOLOGY OF EVENTS LEADING TO NATIONAL CONFERENCE FOR INSTITUTIONS PREPARING HEALTH EDUCATORS

CHRONOLOGY OF EVENTS LEADING TO

National Conference for Institutions Preparing Health Educators
Role Delineation: Implications for Credentialing in Health Education

Birmingham, Alabama, February 5-7, 1981

February 1978	Bethesda Conference on the Commonalities and Differences in the Preparation and Practice of Health Educators.
March 1978	Formation of the National Task Force for the Professional Preparation and Practice of Health Educators.
September 1978	Procurement of support including funds from the Bureau of Health Manpower (now called the Bureau of Health Professions) to the National Center for Health Education for the initial phase of credentialing--initial role specification.
October 1978	Role Delineation Advisory Committee (RDAC) formed.
January 1979	Role Delineation Project Director hired.
February 1979	Role Delineation Working Committee (RDWC) formed.
January 1980	The final draft of the initial role delineation completed.
April 1980	Publication of a final draft of the 'Initial Role Delineation for Health Education" by the U.S. Department of Health and Human Services.
May 1980	Contract for the second phase role verification and refinement awarded to the National Center for Health Education.
July 1980	Issue of FOCAL POINTS on "Health Education and Credentialing: The Role Delineation Project" published by the Bureau of Health Education and the Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine.
September 1980	Role Verification and Refinement Committee (RVRC) formed.
Aug.-Sept. 1982	Planning meetings for the National Conference for institutions Preparing Health Educators held.

ACCREDITATION:

WHO DOES WHAT?

ACCREDITATION: Who Does What?

THE COUNCIL ON POSTSECONDARY ACCREDITATION (COPA)
One Dupont Circle, Northwest, Suite 760
Washington, DC 20036
202/452-1433
Richard M. Millard, President
(effective 2/1/81)

...COPA was organized in January 1975, when the Federation of Regional Accrediting Commissions of Higher Education (FRACHE) and the National Commission on Accrediting (NCA) merged. It is a non-profit corporation.

...Its major purpose is to support, coordinate, and improve all non-governmental accrediting activities conducted at the post-secondary level in the United States.

...The United States has developed a system of non-governmental evaluation called accreditation that plays a central role in evaluating and attesting to educational quality. Accrediting bodies, therefore, are quasi-public entities, with certain public responsibilities to the many groups which interface with the educational community.

...COPA recognizes 52 accrediting bodies... "in order to coordinate and improve non-governmental accreditation."

--There are nine regional accrediting commissions
--There are four national institutional accrediting commissions
--There are 39 specialized (programmatic) accrediting agencies, some of which overlap

...COPA is governed by a Board of 38 members representing institutional and specialized accreditation, national associations of colleges and universities, and the public. Seven major institution-based associations are represented on the Board: The American Council on Education, the American Association of Community and Junior Colleges, the American Association of State Colleges and Universities, the Association of American Colleges, the Association of American Universities, the National Association of Independent Colleges and Universities, and the National Association of State Universities and Land-Grant Colleges.

...COPA derives its financial support from more than 4,000 accredited or accreditation-seeking institutions through COPA-recognized accrediting bodies.

...There are two COPA-recognized specialized accrediting agencies of specific interest to health educators:

--The Council on Education for Public Health
--The National Council for Accreditation of Teacher Education

...COPA publishes COPA: The Balance Wheel for Accreditation, Organization, Membership, and Publications List, annual; A Guide to Recognized Accrediting Agencies, annual; and Accredited Institutions of Postsecondary Education, 1980; a quarterly newsletter, Accreditation; Project Reports and Occasional Papers on topics of special interest.

THE COUNCIL ON EDUCATION FOR PUBLIC HEALTH (CEPH)
1015 Fifteenth Street, Northwest, Suite 403
Washington, DC 20005
202/789-1050
Janet Strauss, Executive Director

...CEPH is recognized by COPA and the U.S. Department of Education to accredit schools of public health and master's degree programs in community health education. It also has preaccreditation authorization for graduate programs in community health/preventive medicine.

...CEPH assumed the accrediting activities of the American Public Health Association in 1974.

...CEPH is structured as an independent agency with corporate membership held by the American Public Health Association (APHA) and the Association of Schools of Public Health (ASPH). A board of eight councilors, including two public representatives, are appointed by the corporate members: three each by APHA and ASPH, with the two public members jointly appointed.

...Financial support comes from accredited schools and programs and those applying for accreditation.

...CEPH publishers Manuals of Standards and the Accreditation Process Manual.

THE NATIONAL COUNCIL FOR ACCREDITATION OF TEACHER EDUCATION (NCATE)
1919 Pennsylvania Avenue, N.W., Suite 202
Washington, DC 20006
202/466-7496
M. M. (Lyn) Goeser, Director

...NCATE is recognized by COPA and the U.S. Department of Education to evaluate and accredit programs that prepare professional educators for positions in K-12 schools for all grades and subjects. Included in NCATE accreditation are programs that prepare various school service personnel. Basic and advanced programs are reviewed.

...NCATE applies standards it has developed to colleges and universities seeking to establish or maintain accreditation. In its 1979-1980 list, 545 college and University programs at basic and advanced levels were accredited.

...NCATE represents ten constituent organizations: American Association of Colleges for Teacher Education, American Association of School Administrators, Council for Exceptional Children, Council of Chief State School Officers, National Association of School Psychologists, National Association of State Directors of Teacher Education and Certification, National Council of Teachers of Mathematics, National Education Association (Instruction and Professional Development), National School Boards Association, Student National Education Association. Representatives from these organizations make up the Council, which governs NCATE. There are four associate organizational members, in addition: American Personnel and Guidance Association, Association for Educational Communications and Technology, Association of Teacher Educators, and National Council for the Social Studies.

...NCATE was initially recognized as an accrediting body in 1952.

...NCATE publishes Standards for the Accreditation of Teacher Education 1979, an Annual List of accredited programs, and NCATE UPDATE, a quarterly newsletter.

DEPARTMENT OF EDUCATION
Office of Postsecondary Education
Bureau of Higher and Continuing Education
Division of Eligibility and Agency Evaluation
Washington, DC 20202

...While accreditation is a voluntary, private effort, federal recognition of an accrediting agency is a prerequisite to eligibility for federal financial assistance for institutions and their students under select federally supported programs. The U.S. Department of Education is responsible for recognizing accrediting agencies for the government's purposes.

..."For purposes of determining eligibility for Federal assistance pursuant to 20 U.S.C. 1141 (a) and other legislation, beginning with the Veteran's Readjustment Assistance Act of 1952, the U.S. Commissioner of Education (the Secretary of Education)...publishes a list of nationally recognized accrediting agencies and associations which he determines to be reliable authorities as to the quality of training offered by educational institutions either in a geographic area or in a specialized field, and the general scope of recognition granted to the accredited bodies."

The list is published in the Federal Register and as the Department of Education's Nationally Recognized Accrediting Agencies and Associations.

Compiled by Elena M. Sliepcevich, Department of Health Education, Southern Illinois University-Carbondale and Alan C. Henderson, Role Delineation Project, National Center for Health Education

December 1980

DEFINITIONS OF CREDENTIALING MECHANISMS

NATIONAL CENTER FOR HEALTH EDUCATION

Role Delineation Project

Definitions of Credentialing Mechanisms*

Accreditation - The process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards.

Licensure - The process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected.

Certification or registration - The process by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association. Such qualifications may include: (a) graduation from an accredited or approved program; (b) acceptable performance on a qualifying examination or series of examination; and/or (c) completion of a given amount of work experience.1/

1/Taken from Report on Licensure and Related Health Personnel Credentialing, June 1971. DHEW Publication No. (HSM) 72-11. Washington, DC: U.S. Government Printing Office. p.7.

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